Supreme Court, U.S.
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No. _____

In The
Supreme Court of the United States

PENNY NELSON, for herself and as Personal Representative of the Estate of Decedent, DOUGLAS NELSON,

Petitioner,

v.

U.S. OFFICE OF PERSONNEL MANAGEMENT,

Respondent.

On Petition For A Writ Of Certiorari To The United States Court Of Appeals For The Ninth Circuit

PETITION FOR A WRIT OF CERTIORARI

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February 17, 2006

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QUESTION PRESENTED

Whether the Ninth Circuit erred by failing, in contravention of federal common law, to construe an ambiguous insurance contract that was issued pursuant to the Federal Employees Health Benefits Act, 5 U.S.C. §8901 et seq. (FEHBA) in favor of the insured.

STATEMENT REQUIRED BY RULE 14.1

Pursuant to Supreme Court Rule 14.1, petitioner states that all parties to the proceeding in the court whose judgment is sought to be reviewed are included in the caption.

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PETITION FOR A WRIT OF CERTIORARI

Petitioner Penny Nelson, personal representative of the estate of Douglas Nelson, respectfully petitions for a writ of certiorari to review the judgment of the United States Court of Appeals for the Ninth Circuit in this case.

OPINIONS BELOW

The order of the Court of Appeals on the Nelson's petition for rehearing and suggestion of rehearing en banc was entered on November 23, 2005, is unreported and is reprinted in the Appendix to this Petition ("Pet. App.") at 19. The underlying opinion of the Court of Appeals was entered on September 8, 2005, is unreported and is reprinted at Pet. App. 1-3. The order of the United States District Court for the Western District of Washington granting summary judgment was entered on February 3, 2004, is unreported and is reprinted at Pet. App. 4-12.

JURISDICTION

The opinion of the Court of Appeals was entered on September 8, 2005 and the order of the Court of Appeals denying Nelson's petition for rehearing and suggestion of rehearing en banc was entered on November 23, 2005. This Court has jurisdiction pursuant to 28 U.S.C. § 1254(1).

RELEVANT STATUTORY PROVISIONS

This petition involves the following provisions of the Federal Employees Health Benefits Act, 5 U.S.C. §§ 8902(e) and (j), 8903, 8907, and 8912, which are reprinted at Pet. App. 20-25.

STATEMENT OF THE CASE

Petitioner is the widow of a career federal employee; her husband, Douglas Nelson worked as a machinist and in the planning and estimating office at the Puget Sound Naval Shipyard in Bremerton, Washington. As a result of his work at the shipyard, he was exposed to asbestos and contracted mesothelioma, an incurable cancer of the lining of the lung that typically kills its victims within months. Pet. App. 32. After being diagnosed with mesothelioma, Mr. Nelson filed a worker's compensation claim through the federal Office of Workers' Compensation Programs ("OWCP") and a civil lawsuit against the companies whose asbestos products he was exposed to. OWCP determined that his mesothelioma was work-related and began covering the medical services he received to treat his cancer. After he settled his case against the asbestos manufacturers for approximately $1.3 million,[1] OWCP stopped paying anything for his care, and Mr. Nelson paid OWCP back the funds already expended on his behalf. Pet. App. 35-36. OWCP further notified Mr. Nelson that it would not pay any further benefits until he had expended $520,330.77 for medical or other needs related to his mesothelioma. Pet. App. 34.

[1] This is a gross figure, before fees, costs and liens were taken out.

Mr. Nelson also carried health insurance through Kitsap Physicians' Service ("KPS"), an approved carrier under FEHBA. When he was notified that OWCP would not cover his medical care, he began submitting claims to his insurance company, KPS. At first, KPS paid the claims; however, in April of 2001 it began denying coverage based on the following exclusion clause:

> We do not cover services that:
>
> - You need because of a workplace-related illness or injury that the Office of Workers' Compensation Programs (OWCP) or a similar Federal or State agency determines they must provide; or
> - OWCP or a similar agency pays for through a third party injury settlement or other similar proceeding that is based on a claim you filed under OWCP or similar laws.

Pet. App. 17. This "workers compensation exclusion" was contained in a summary of benefits provided to Mr. Nelson pursuant to the Federal Employment Health Benefits Act, 5 U.S.C. § 8907(b)(1), which requires carriers approved under FEHBA to provide those federal employees who enroll in a plan with a document "summarizing the services or benefits, including maximums, limitations, and exclusions. . . ."

In this case, OWCP determined that Mr. Nelson was ***not*** eligible for benefits and did ***not*** pay for or provide medical services for Mr. Nelson. Thus, Mr. Nelson challenged KPS' denial of his claims on the basis of an exclusionary clause that, by its terms, applied to those whose medical services ***were*** being paid for by OWCP. Pursuant to the administrative procedures set forth in 5 C.F.R.

§ 890.105, Mr. Nelson sought review of the decision from the Office of Personnel Management ("OPM"). Under FEHBA, OPM has the authority to order an insurer to pay a benefits claim. 5 U.S.C. § 8902(j). Instead, OPM ruled that "KPS's decision to deny benefits is contractually correct," citing the language of the exclusion clause quoted above. Pet. App. 17. OPM later issued a revised decision, explaining the process by which OWCP denied benefits to Mr. Nelson because of his third party lawsuit against the asbestos companies. Pet. App. 13-15. In this new decision, OPM again stated that its decision against Mr. Nelson was based on the language of the exclusionary clause in the summary of benefits quoted above. *Id.*

Mr. Nelson appealed OPM's decision to the federal district court of the Western District of Washington, which had jurisdiction of the matter pursuant to 5 U.S.C. § 8912. The district court upheld the denial of benefits, and Mr. Nelson appealed to the Ninth Circuit, which similarly upheld the denial of benefits, ruling that the workers compensation exclusion applied. The Court further quoted and apparently relied on a portion of the KPS summary of benefits that informs the insured when the carrier ***will*** pay benefits; it provides as follows:

> Once OWCP or similar agency pays its maximum benefits for your treatment, we will cover your care. You must use our providers.

Pet. App. 42. This provision was not referred to by OPM in either of its decisions. Pet. App. 13-18.

Mr. Nelson outlived the odds and survived eight years following his diagnosis with mesothelioma. The cost of his cancer treatment during that period is at issue in this petition. He died on May 23, 2005; his widow has been

named as the personal representative of his estate and substituted as the appellant/petitioner in this matter.

REASONS FOR GRANTING THE PETITION

Certiorari is warranted in this case brought under the Federal Employees Health Benefits Act because the Ninth Circuit failed to apply federal common law regarding the interpretation of ambiguous provisions in insurance contracts. Thus its opinion is in conflict with the law of virtually every circuit that has ruled on the issue, including the Ninth Circuit.

Although the Court of Appeal's unpublished opinion did not expressly address the issue, the ambiguous nature of the contract language at issue is patent. The contract essentially says that the carrier will not pay benefits when OWCP is paying them. It says nothing about the situation such as Mr. Nelson's where OWCP found him to have an occupational disease but not eligible for payment of the cost of medical services because of his third party settlement. As to that scenario, the "workers compensation exclusion" in the contract is, at best, ambiguous.

The Court of Appeals also relied on a statement in the plan's summary of benefits that the carrier ***will*** pay for the insured's care, once OWCP has paid its maximum benefits. If this section of the plan summary was supposed to be part of the notice to the insured that the carrier would ***not*** provide coverage when OWCP had ***not*** paid any benefits, it certainly did not make that plain and clear. Thus, ambiguities exist in both contract provisions cited by the Court of Appeals for its decision, yet the Court applied an interpretation of the contract that ***disfavored*** the insured.

In the ERISA context, it has been held that an exclusionary clause may not be enforced unless it is set forth in language clear enough for an ordinary lay person to understand. *Saltarelli v. Baker Group Medical Trust*, 35 F.3d 382, 386 (9th Cir. 1994); *Phillips v. Lincoln National Life Ins. Co.*, 978 F.2d 302, 313 (7th Cir. 1992); *Kunin v. Benefit Life Ins. Co.*, 910 F.2d 534, 539-540 (9th Cir. 1990), *cert. denied*, 498 U.S. 1013, 111 S.Ct. 581, 112 L.Ed.2d 25 (1990); *Heller v. Equitable Life Assurance Society*, 833 F.2d 1253, 1256 (7th Cir. 1987). Where there is ambiguity, ERISA cases and federal common law have applied the principle of *contra proferentem* to hold that the interpretation that favors the ***insured*** applies. *Regents of University of Michigan v. Employees of Agency Rent-A-Car*, 122 F.3d 336, 340 (6th Cir. 1997); *Phillips*, 978 F.2d at 311-312; *Masella v. Blue Cross & Blue Shield of Connecticut, Inc.*, 936 F.2d 98, 107 (2nd Cir. 1991); *Kunin*, 910 F.2d 539-540; *see also, Heasley v. Belden & Blake*, 2 F.3d 1249, 1257-1258 (3rd Cir. 1993) (applying the doctrine of *contra proferentem* to interpret an ambiguous provision in an ERISA plan regarding the standard of review of the plan administrator's decision). Only the Eighth Circuit has held to the contrary, declining, on preemption grounds, to import the doctrine of *contra proferentem* from Missouri state law into the federal ERISA context. *Brewer v. Lincoln Nat. Life Ins. Co.*, 921 F.2d 150, 153-154 (8th Cir. 1990).

In this case, the Ninth Circuit Court of Appeals, citing no authority, interpreted contract provisions that did not by their terms cover the situation at issue in a manner that ***disfavored*** the insured. Its decision presents the question of whether law that has developed under ERISA and federal common law regarding the interpretation of ambiguous contract clauses applies to cases arising under

FEHBA. There are sound policy reasons for doing so and no meaningful reason for distinguishing FEHBA contracts from contracts governed by ERISA. As with most ERISA plans, the insured has no ability to bargain with the carrier for more favorable contract terms. Further, it makes sense for the federal courts to adopt one uniform and predictable body of federal common law to apply in construing contracts controlled by federal law.

Accordingly, certiorari should be granted to provide guidance to the lower courts as to whether the doctrine of *contra proferentem* should be applied in interpreting ambiguous clauses in FEHBA contracts.

Respectfully submitted,

KRISTIN HOUSER*
SCHROETER GOLDMARK & BENDER
810 Third Avenue, Suite 500
Seattle, WA 98104
206/622-8000

February 17, 2006

Counsel for Petitioner

**Counsel of Record*

APPENDIX A

NOT FOR PUBLICATION

UNITED STATES COURT OF APPEALS

FOR THE NINTH CIRCUIT

DOUGLAS NELSON, Plaintiff-Appellant, v. U.S. OFFICE OF PERSONNEL MANAGEMENT, Defendant-Appellee.	No. 04-35108 D.C. No. CV-03-05135-FDB MEMORANDUM* (Filed Sep. 08, 2005)

Appeal from the United States District Court
for the Western District of Washington
Franklin D. Burgess, District Judge, Presiding

Argued and Submitted August 29, 2005
Seattle, Washington

Before: BEEZER, THOMPSON, and McKEOWN, Circuit Judges.

Douglas Nelson appeals the district court's order granting summary judgment in favor of the United States Office of Personnel Management (OPM) and denying his motion for summary judgment. Nelson contends that the district court erred in upholding OPM's decision. OPM determined that because the Office of Workers' Compensation Programs (OWCP) accepted Nelson's workers' compensation claims,

* This disposition is not appropriate for publication and may not be cited to or by the courts of this circuit except as provided by Ninth Circuit Rule 36-3.

his medical claims arising from his asbestos-related illness are excluded from coverage under the KPS Health Plan.

Nelson and his wife received $1.3 million in settlement of their lawsuits against various asbestos products manufacturers. As provided by 5 U.S.C. § 8132, Nelson reimbursed OWCP for medical bills it had paid on his behalf (less a deduction for attorneys' fees and expenses). OWCP notified Nelson that he would be responsible for medical expenses out of the settlement until a statutory surplus amount had been expended, at which point OWCP would again begin paying for his medical expenses. Neither party disputes the amount of the surplus. Instead of paying his medical expenses, Nelson submitted his medical claims to KPS, which paid over $180,000 in medical expenses before notifying him that the expenses for this work-related injury were excluded under his insurance contract.

We note that neither party has provided the court with the actual KPS insurance contract under which Nelson sought benefits. Instead, both parties premise their arguments on the KPS Health Plan Brochure (the KPS Brochure). As a consequence, for purposes of this appeal we treat the KPS Brochure as the "contract," the controlling document for interpretation.

OPM's decision was based upon contract interpretation as well as the applicable statutes, including 5 U.S.C. §§ 8132 and 8101(12). Ultimately OPM concluded that Nelson's claims "as determined in accordance with the rule crediting surplus on future payments of compensation" were specifically excluded from coverage under the KPS Brochure.

Whether we review de novo OPM's decision on the contract, *see Texas Gas Transmission Corp. v. Shell Oil Co.*, 363 U.S. 263, 268-70 (1960), or give deference to OPM's interpretation of the contract, *see Arizona Cattle Growers' Ass'n v. U.S. Fish & Wildlife*, 273 F.3d 1229, 1236-37 (9th Cir.2001) (citing *Chevron, U.S.A., Inc. v. Natural Res. Def. Council, Inc.*, 467 U.S. 837, 842 (1984)), the result is the same.

The KPS Brochure plainly states that it does not cover services that Nelson needed "because of a workplace related illness or injury that the Office of Workers' Compensation Programs.... *determines they must* provide" (emphasis added). Nelson's asbestos-related illness falls within this proviso. The KPS Brochure further provides that "once OWCP or similar agency pays its maximum benefits for [claimant's] treatment," KPS will cover his care. Because the KPS Brochure excludes coverage for medical services related to Nelson's asbestos-related disease and because OWCP has not paid the maximum benefits, we affirm OPM's decision.

KPS is not a party to this litigation. We do not decide whether Nelson has an obligation to reimburse KPS for medical expenses it paid on his behalf.

Nelson's counsel advised the court that Nelson died in May 2005. Upon the filing of a motion under Fed. R. App. P. 43(a)(1), we will substitute the appropriate party.

AFFIRMED.

APPENDIX B

UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF WASHINGTON
AT TACOMA

DOUGLAS NELSON, Plaintiff, v. UNITED STATES OFFICE OF PERSONNEL MANAGEMENT, Defendant.	Case No. C03-5135FDB ORDER DENYING PLAINTIFF'S MOTION FOR SUMMARY JUDGMENT AND GRANTING DEFENDANT'S CROSS MOTION FOR SUMMARY JUDGMENT

This matter comes before the Court on Plaintiff Douglas Nelson's (Nelson) motion for summary judgment and Defendant United States Office of Personnel Management's (OPM) cross-motion for summary judgment. As the facts are not in dispute, the Court reviews the matter on the parties' motions, affidavits, and evidence. The Court finds, for the reasons set forth below, that OPM did not act arbitrarily or capriciously when it denied Mr. Nelson's health insurance claims.

I. BACKGROUND

The facts in this action are not in dispute. In 1997, Mr. Nelson was diagnosed with mesothelioma, a form of lung cancer related to asbestos exposure. Mr. Nelson and his wife filed suit against numerous asbestos manufacturers and filed a claim for workers compensation benefits under the Federal Employees Compensation Act. In May 1997, the Office of Workers Compensations Programs (OWCP) determined that Mr. Nelson's illness was related

to his federal employment, accepted his claim for payment, and began paying his medical bills.

In 1998, Mr. and Mrs. Nelson settled their lawsuit against the asbestos manufacturers. Although some of the asbestos manufacturers had gone bankrupt and paid percentages of their agreed upon settlements, Mr. and Mrs. Nelson received a total of $1.3 million in settlement of their claims. Mr. Nelson reimbursed OWCP for the medical bills it had paid to date, less a deduction for attorney fees and expenses. OWCP then notified Mr. Nelson that, because he had received a recovery from third parties responsible for his work-related injury, he would be required to pay his medical expenses out of his settlement until the "surplus" recovery had been expended. At that time, OWCP would resume paying for his medical bills resulting from his work-related injury. If Mr. Nelson applied for a lump sum payment based on permanent disability, that amount would be credited against the "surplus." Based upon a statutory formula, OWCP determined that the "surplus" totaled $520,330.77.

Mr. Nelson did not apply for a lump sum payment or pay for his medical expenses, but submitted his claims to his insurance carrier, KPS. KPS provides health insurance to federal employees under a health benefits program administered by OPM. KPS paid $180,927.09 in medical expenses until April 2001, when it notified Mr. Nelson that his claims for medical expenses arising out of his work-related injury were rejected and that he must reimburse KPS for the expenses it had already paid.

KPS' decision to deny benefits for medical services related to Mr. Nelson's asbestos-related disease was based

on exclusionary provisions contained in the insurance contract:

> We do not cover services that:
>
> You need because of a workplace-related illness or injury that the Office of Workers' Compensation Programs (OWCP) or a similar Federal or State agency determines they must provide; or
>
> OWCP or a similar agency pays for through a third party injury settlement or other similar proceeding that is based on a claim you filed under OWCP or similar laws.
>
> Once OWCP or a similar agency pays its maximum benefits for your treatment, we will cover your care. You must use our providers.

The contract also provides:

> When you receive money to compensate you for medical or hospital care for injuries or illnesses caused by another person, you must reimburse us for any expenses we paid. However, we will cover the cost of treatment that exceeds the amount you received in this settlement. If you do not seek damages you must agree to let us try. This is called subrogation.

Mr. Nelson requested that KPS reverse its denial of benefits. KPS upheld its decision on August 2, 2002. On October 4, 2002, Mr. Nelson sought review of KPS' denial of benefits through the OPM under the provisions of 5 C.F.R. § 890.105(e). On January 2, 2003, the OPM issued its administrative review letter upholding KPS's decision and instructing Mr. Nelson to repay to KPS the sum of $180,953.10. On November 18, 2003, OPM again affirmed the denial and clarified the basis for its determination that

KPS was contractually correct in denying the benefits. In its letter of denial, OPM explained that OWCP had accepted Mr. Nelson's illness as work-related, entitling him to workers compensation and that such acceptance was subject to the requirements of The Federal Employees' Compensation Act, 5 U.S.C. § 813 (FECA). OPM further explained that FECA specifically requires that the employee not only reimburse the United States for any benefits out of the proceeds of lawsuits and settlements related to the illness or injury, but also to credit excess recoveries against future workers compensation benefits. Thus, while Mr. Nelson remains eligible for workers compensation benefits, he is currently in a surplus status because of his settlements, which must be credited against his benefits. Because KPS' Statement of Benefits excludes coverage from any workplace-related illness or injury accepted by OWCP, OPM, therefore, confirmed KPS' denial of benefits as correct.

II. STANDARD OF REVIEW

Under the Federal Employee Health Benefits Act (FEHBA), the United States, through the OPM, enters into annual federal procurement contracts with various private health care carriers to offer health benefit plans with a variety of coverage levels and costs to federal employees. 5 U.S.C. § 8903. Congress delegated to OPM the authority to negotiate the health benefit contracts, to promulgate regulations and to administer the program. 5 U.S.C. §§ 8902, 8913. The federal employee does not enter into a separate contract with the carrier, but is a third-party beneficiary of the contract between OPM and the carrier. *See Caudhill v. Blue Cross and Blue Shield of North Carolina*, 999 F.2d 74, 76 (4th Cir. 1993).

Federal employees who enroll in the program must be provided a Statement of Benefits setting forth an explanation of the plan "benefits, including maximums, limitations, and exclusions." 5 U.S.C. § 8907(b). The Statement of Benefits is incorporated by reference into the contract between OPM and the carrier and is the official and exclusive description of the plan benefits. *Id.* Under FEHBA, a carrier must pay a benefits claim if OPM finds that the contract entitles an individual to such payment. 5 U.S.C. § 8902(j). OPM has established by regulation an administrative review process for an individual who believes that a carrier has improperly denied a claim. 5 C.F.R. § 890.105 (1992).

OPM's denial of Mr. Nelson's benefits represents a final determination by an administrative agency. *Berry v. Blue Cross of Washington and Alaska.* 815 F.Supp. 359, 361 (W.D.Wa. 1993). OPM's interpretations of FEHBA plans are subject to review under the arbitrary and capricious standard. *Berry*, 815 F. Supp. at 361 (*citing Carolyn Arrington v. Group Hospitalization and Medical Services, Inc.*, 806 F.Supp. 287 (D.D.C. 1992); *Dixie L. Roseberry v. Blue Cross and Blue Shield of Nebraska*, No. 8:CV 92-371 (D.Neb. Dec. 18, 1992).[1] The opinions of OPM regarding

[1] Plaintiff argues that OPM cannot successfully argue that it has advantage over this Court in the task of contract interpretation, a classic question of law. However, the OPM "does have relevant expertise in this area because it negotiates the contracts at issue and, pursuant to the FEHBA, routinely inteprets [sic] plans to determine an insurance carrier's liability. *Muratore v. U.S. Office of Personnel Management*, 222 F.3d 918, 923 (11th Cir. 2000) (*citing* 5 U.S.C. § 8902(e) (allowing OPM to prescribe minimum standards for benefit plans). Additionally, "OPM has the ability to take a broad, national view when it inteprets plans which serves the function of ensuring consistent, nationwide application. *Id.* (*citing, Caudill*, 999 F.2d at 79)).

interpretation of its contracts with carriers are entitled to deference. *Berry*, 815 F.Supp. at 361.

Mr. Nelson argues that the facts of his case are analogous to those presented to the Court in *Berry*. *Berry* involved an insurance plan, containing the exclusionary language at issue, and a separate booklet, upon which the plaintiffs claimed they relied, which did not contain the exclusionary language. *Berry*, 815 F.Supp. at 361. While OPM had reviewed and resolved that the plan did not provide coverage, it had never considered or decided whether the booklet did. Because there were material issues of fact in dispute as to whether the booklet was the disclosure document required by § 8907(b) and whether plaintiffs were entitled to rely on the booklet, the Court denied the parties' cross-motions for summary judgment.

The facts of this case are not analogous to those in *Berry*. There is no dispute in this case as to the exclusionary language at issue, that it was contained in the plan information received by Mr. Nelson, and that it was included in the scope of OPM's review. Therefore, the Court will defer to OPM's interpretation of the contract at issue so long as that interpretation is reasonable and relies on ample factual and legal support.

III. RECORD BEFORE THE OPM

There is no dispute that the factual record before the OPM was complete or that OPM's decision is sufficiently detailed to permit judicial review. *See, e.g.*, Dkt. #9. After KPS denied Mr. Nelson's request for coverage, Mr. Nelson provided medical, financial and legal documentation to KPS to support his claim that KPS should reverse its decision. In its review of KPS' decision, OPM requested a

full report and obtained all the documentation that was before KPS. Mr. Nelson provided information to OPM about his claim including all correspondence with KPS, medical bills, information about his prior lawsuit, and a declaration from his treating doctors.

OPM's review also included KPS' denial of benefits and explanation, KPS' reconsideration of its denial, the Statement of Benefits, OWCP's letters accepting Mr. Nelson's illness as work-related and awarding benefits, OWCP's determination that surplus compensation would be credited against Mr. Nelson's entitlement to workers compensation benefits until the surplus was exhausted, and the laws and regulations governing payment of OWCP benefits.

IV. CONTRACTUAL INTERPRETATION

The parties agree that Mr. Nelson's illness was work-related, entitling him to workers compensation benefits. The parties also agree that OWCP paid Mr. Nelson's claims until the Nelsons received their $1.3 million settlement from the asbestos manufacturers, at which time OWCP advised Mr. Nelson that he would be required to pay his medical expenses out of his settlement until the "surplus" recovery had been expended. OPM affirmed KPS' denial of Mr. Nelson's claims based on the worker compensation exclusion, interpreting that provision to mean that once OWCP accepted Mr. Nelson's workers' compensation claims, his medical claims related to the asbestos related illness are specifically excluded from coverage under the plan. Mr. Nelson counters that so long as the "surplus" exists, OWCP is not paying any of Mr. Nelson's claims and

Mr. Nelson is not receiving any benefits. Therefore, Mr. Nelson argues, KPS is required to cover his claims.

Mr. Nelson also argues that the language of the insurance contract is ambiguous and, therefore, must be interpreted in his favor. The Court does not agree. The Court concludes that OPM did not act arbitrarily or capriciously in affirming KPS' denial of Mr. Nelson's claim. OPM offers a reasonable interpretation that, although OWCP is not currently paying Mr. Nelson's medical expenses, it has not paid its "maximum benefits." Because OWCP accepted Mr. Nelson's claim, it is contractually obligated to provide medical services for Mr. Nelson's asbestos-related condition. Thus, if Mr. Nelson personally pays his medical expenses and those expenses exceed the surplus, OWCP must resume payment of worker compensation benefits to Mr. Nelson.

Mr. Nelson's suggested interpretation ignores the effect of Mr. Nelson's "surplus" status. It also ignores that the OWCP has determined that it will pay Mr. Nelson's benefits, will resume payment of Mr. Nelson's benefits when the surplus is used up, and will pay until it has paid its maximum benefits. The interpretation urged by Mr. Nelson is also based, in part; on the argument that Mr. Nelson may never use up the surplus. Thus, he argues, OWCP's obligation to resume payment might never be triggered. This argument ignores that there is an obligation to resume and that Mr. Nelson remains eligible for workers compensation benefits. Mr. Nelson is, therefore, incorrect that OPM's decision is based on a "theoretical future eligibility."

The Court does not find that the OPM acted arbitrarily or capriciously when it affirmed KPS' interpretation of

the insurance plan. OPM's decision was reasonable and, after considering the relevant factors, was rationally based on the facts and contractual interpretation. The Court will defer to OPM's judgment.

ACCORDINGLY,

IT IS ORDERED:

(1) Plaintiff's motion for summary judgment (Dkt.#19) is DENIED;

(2) Defendant's cross-motion for summary judgment (Dkt#21) is GRANTED; and

(3) The Clerk is directed to enter judgment in favor of Defendant United States Office of Personnel Management.

DATED this 3rd day of February, 2004.

/s/ Franklin D. Burgess
FRANKLIN D. BURGESS
UNITED STATES
DISTRICT JUDGE

APPENDIX C

United States
Office of
Personnel Management Washington, D.C. 20415

In Reply Refer To: Y02340010
Your References: 531-42-1781

NOV 18 2003

Schroeter Goldmark & Bender
500 Central Building
810 Third Avenue
Seattle, WA 98104

Dear Ms. Widlan:

The Office of Personnel Management (OPM) has completed its final administrative review. The dispute in question involves medical services related to Mr. Douglas Nelson's asbestos related illness incurred from December 2, 1996 through November 5, 2002. KPS denied benefits for these medical services as not contractually covered.

The documentation you provided indicates that Mr. Nelson's asbestos-related disease was contracted as a result of a workplace exposure and his claims for workers' compensation benefits were accepted by the Office of Workers' Compensation Programs in a letter from claims examiner Kenneth Dowdell dated May 6, 1997. Mr. Nelson subsequently entered into a number of settlements in a lawsuit he had filed against a variety of parties connected with his asbestos exposure. Following the settlements OWCP determined that Mr. Nelson had a surplus on his workers' compensation claim and asserted that it had no obligation to pay further workers' compensation benefits until Mr. Nelson's medical expenses exceed the surplus

amount and OWCP will resume payment of compensation once Mr. Nelson's surplus has been absorbed. According to OWCP, as of April of 2002, the surplus amount was $93,965.21.

The Federal Employee's Compensation Act (FECA), 5 U.S.C. § 8132, provides that the employee "shall refund to the United States the amount of compensation paid by the United States and credit any surplus on future payments of compensation payable to him for the same injury." Further, 5 U.S.C. § 8181(12) also provides that compensation "includes the money allowance payable to an employee or his dependents and any other benefits paid for from the Employees' Compensation Fund . . ." Medical benefits under the FECA are paid for from the Employees' Compensation Fund.

In your letter dated October 4, 2002, you indicated that workers' compensation has determined that it does not have to provide any benefits on behalf of Mr. Nelson. Thus, it is your contention that the KPS' exclusion for workers' compensation does not apply. However, after reviewing this case and the applicable regulations, we determined that KPS' decision to deny benefits for medical services related to Mr. Nelson's asbestos-related disease is contractually correct. Page 45 of the 2002 KPS Health Plans brochure states: ***"We do not cover services that:***

- ***You need because of a workplace-related illness or injury that the Office of Workers' Compensation Programs (OWCP) or a similar Federal or State agency determines they must provide; or***

- ***OWCP or a similar agency pays for through a third party injury settlement or other similar***

preceding that is based on a claim you filed under OWCP or similar laws."

Under the KPS workers' compensation brochure provision, when OWCP determines that they must provide a benefit, they must provide that benefit in accordance with applicable law and rules, including 5 U.S.C. §8132. Because OWCP has accepted Mr. Nelson's workers' compensation claims (as determined in accordance with the rule crediting surplus on future payments of compensation), his medical claims related to the asbestos related illness are specifically excluded from coverage under the KPS Health Plan.

The claims in dispute are not contractually covered. OPM concurs with KPS's decision to deny benefits for medical services provided for Mr. Nelson's asbestos related illness. This is OPM's final administrative review.

Sincerely,

/s/ Nikki L. Hentemann
Nikki L. Hentemann, PAHM, HIA
Insurance Benefits Claims Examiner
Health Insurance Group II
Insurance Services Programs

APPENDIX D

United States
Office of
Personnel Management Washington, D.C. 20415

In Reply Refer To: Your Reference:
Y02340010 531-42-1781
January 2, 2003

Schroeter Goldmark & Bender
500 Central Building
810 Third Avenue
Seattle, WA 98104

Dear Ms. Widlan:

This is in response to your October 4, 2002 letter requesting that the Office of Personnel Management (OPM) review your health benefits claim dispute on behalf of your client, Mr. Douglas Nelson, with the KPS Health Plans under the Federal Employees Health Benefits (FEHB) Program. The disputed claim concerns the Plan's denial of benefits for medical services related to Mr. Nelson's asbestos-related illness incurred from December 2, 1996 through November 5, 2002.

The documentation you provided indicates that Mr. Nelson's asbestos-related disease was contracted as a result of a workplace exposure and his claims for worker's compensation benefits was accepted by the Office of Workers' Compensation Programs in a letter from claims examiner Kenneth Dowdell dated May 6, 1997. Mr. Nelson subsequently entered into a number of settlements in a lawsuit he had filed against a variety of parties connected with his asbestos exposure. Following the settlements OWCP determined that Mr. Nelson had a surplus on his workers compensation claim and asserted that it had no obligation

to pay further workers' compensation benefits until Mr. Nelson's medical expenses exceed the surplus amount and OWCP will resume payment of compensation once Mr. Nelson's surplus has been absorbed.

In your letter dated October 4, 2002, you indicated that Workers' compensation has determined that it does not have to provide any benefits on behalf of Mr. Nelson. Thus, KPS' exclusion for workers' compensation does not apply. However, after reviewing this case and the applicable regulations, we determined that KPS' decision to deny benefits for medical services related to Mr. Nelson's asbestos-related disease is contractually correct as stated on page 45 of the 2002 KPS Health Plans brochure, ***"We do not cover services that:***

- ***You need because of a workplace-related illness or injury that the Office of Workers' Compensation Programs (OWCP) or a similar Federal or State agency determines they must provide; or***

- ***OWCP or a similar agency pays for through a third party injury settlement or other similar preceding that is based on a claim you filed under OWCP or similar laws."***

Further, KPS, in accordance with their contract with OPM, is obligated to subrogate, as stated on page 45 of the 2002 KPS Health Plans brochure, ***"When you receive money to compensate you for medical or hospital care for injuries or illnesses caused by another person, you must reimburse us for any expenses we pair. However, we will cover the cost of treatment that exceeds the amount you received in this settlement. If you do not seek damages you must agree to let us try. This is called subrogation."***

KPS' records indicate they KPS overpaid claims for Mr. Nelson's asbestos-related illness in the amount of $180,953.10. We request that you coordinate with KPS regarding payment arrangements for reimbursement of the overpaid amount. We maintain the Plan's decision. The Plan has a responsibility to provide or deny benefits in accordance with the terms, coverage limitations, and exclusions contained in the brochure. Our review is based on the contract and the services in dispute. This is the final administrative review of this disputed claim OPM. If you wish to pursue this matter further, your only recourse is to file suit against OPM in Federal District Court.

Sincerely,

/s/ Nikki L. Hentemann
Nikki L. Hentemann
Insurance Benefits Claims Examiner
Office of Insurance Programs

APPENDIX E

UNITED STATES COURT OF APPEALS

FOR THE NINTH CIRCUIT

DOUGLAS NELSON, Plaintiff-Appellant, V. U.S. OFFICE OF PERSONNEL MANAGEMENT, Defendant-Appellee.	No. 04-35108 D.C. No. CV-03-05135-FDB Western District of Washington, Tacoma ORDER

(Filed Nov. 23, 2005)

Before: BEEZER, THOMPSON, and McKEOWN, Circuit Judges.

The panel has voted to deny the petition for panel rehearing and to deny the petition for rehearing en banc.

The full court has been advised of the petition for rehearing and rehearing en banc, and no judge has requested a vote on whether to rehear the matter en banc. Fed. R. App. P. 35.

The petition for panel rehearing and the petition for rehearing en banc are denied.

APPENDIX F

5 U.S.C. § 8902 (2005). Contracting authority

(a) The Office of Personnel Management may contract with qualified carriers offering plans described by section 8903 or 8903a of this title, without regard to section 5 of title 41 or other statute requiring competitive bidding. Each contract shall be for a uniform term of at least 1 year, but may be made automatically renewable from term to term in the absence of notice of termination by either party.

(b) To be eligible as a carrier for the plan described by section 8903(2) of this title, a company must be licensed to issue group health insurance in all the States and the District of Columbia.

(c) A contract for a plan described by section 8903(1) or (2) of this title shallequire the carrier –

(1) to reinsure with other companies which elect to participate, under an equitable formula based on the total amount of their group health insurance benefit payments in the United States during the latest year for which the information is available, to be determined by the carrier and approved by the Office; or

(2) to allocate its rights and obligations under the contract among its affiliates which elect to participate, under an equitable formula to be determined by the carrier and the affiliates and approved by the Office.

(d) Each contract under this chapter shall contain a detailed statement of benefits offered and shall include such maximums, limitations, exclusions, and other definitions of benefits as the Office considers necessary or desirable.

(e) The Office may prescribe reasonable minimum standards for health benefits plans described by section 8903 or 8903a of this title and for carriers offering the plans. Approval of a plan may be withdrawn only after notice and opportunity for hearing to the carrier concerned without regard to subchapter II of chapter 5 and chapter 7 of this title. The Office may terminate the contract of a carrier effective at the end of the contract term, if the Office finds that at no time during the preceding two contract terms did the carrier have 300 or more employees and annuitants, exclusive of family members, enrolled in the plan.

(f) A contract may not be made or a plan approved which excludes an individual because of race, sex, health status, or, at the time of the first opportunity to enroll, because of age.

(g) A contract may not be made or a plan approved which does not offer to each employee, annuitant, family member, former spouse, or person having continued coverage under section 8905a of this title whose enrollment in the plan is ended, except by a cancellation of enrollment, a temporary extension of coverage during which he may exercise the option to convert, without evidence of good health, to a nongroup contract providing health benefits. An employee, annuitant, family member, former spouse, or person having continued coverage under section 8905a of this title who exercises this option shall pay the full periodic charges of the nongroup contract.

(h) The benefits and coverage made available under subsection (g) of this section are noncancelable by the carrier except for fraud, overinsurance, or nonpayment of periodic charges.

(i) Rates charged under health benefits plans described by section 8903 or 8903a of this title shall reasonably and equitably reflect the cost of the benefits provided. Rates under health benefits plans described by section 8903(1) and (2) of this title shall be determined on a basis which, in the judgment of the Office, is consistent with the lowest schedule of basic rates generally charged for new group health benefit plans issued to large employers. The rates determined for the first contract term shall be continued for later contract terms, except that they may be readjusted for any later term, based on past experience and benefit adjustments under the later contract. Any readjustment in rates shall be made in advance of the contract term in which they will apply and on a basis which, in the judgment of the Office, is consistent with the general practice of carriers which issue group health benefit plans to large employers.

(j) Each contract under this chapter shall require the carrier to agree to pay for or provide a health service or supply in an individual case if the Office finds that the employee, annuitant, family member, former spouse, or person having continued coverage under section 8905a of this title is entitled thereto under the terms of the contract.

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5 U.S.C. § 8903. Health benefits plans

The Office of Personnel Management may contract for or approve the following health benefits plans:

(1) Service Benefit Plan. One Government-wide plan, which may be underwritten by participating affiliates licensed in any number of States, offering two levels of

benefits, under which payment is made by a carrier under contracts with physicians, hospitals, or other providers of health services for benefits of the types described by section 8904(1) of this title given to employees, annuitants, members of their families, former spouses, or persons having continued coverage under section 8905a of this title, or, under certain conditions, payment is made by a carrier to the employee, annuitant, family member, former spouse, or person having continued coverage under section 8905a of this title.

(2) Indemnity Benefit Plan. One Government-wide plan, offering two levels of benefits, under which a carrier agrees to pay certain sums of money, not in excess of the actual expenses incurred, for benefits of the types described by section 8904(2) of this title.

(3) Employee Organization Plans. Employee organization plans which offer benefits of the types referred to by section 8904(3) of this title, which are sponsored or underwritten, and are administered, in whole or substantial part, by employee organizations described in section 8901(8)(A) of this title, which are available only to individuals, and members of their families, who at the time of enrollment are members of the organization.

(4) Comprehensive Medical Plans.

(A) Group-practice prepayment plans. Group-practice prepayment plans which offer health benefits of the types referred to by section 8904(4) of this title, in whole or in substantial part on a prepaid basis, with professional services thereunder provided by physicians practicing as a group in a common center or centers. The group shall include at least 3 physicians who receive all or a substantial part of their professional income from the

prepaid funds and who represent 1 or more medical specialties appropriate and necessary for the population proposed to be served by the plan.

(B) Individual-practice prepayment plans. Individual-practice prepayment plans which offer health services in whole or substantial part on a prepaid basis, with professional services thereunder provided by individual physicians who agree, under certain conditions approved by the Office, to accept the payments provided by the plans as full payment for covered services given by them including, in addition to in-hospital services, general care given in their offices and the patients' homes, out-of-hospital diagnostic procedures, and preventive care, and which plans are offered by organizations which have successfully operated similar plans before approval by the Office of the plan in which employees may enroll.

(C) Mixed model prepayment plans. Mixed model prepayment plans which are a combination of the type of plans described in subparagraph (A) and the type of plans described in subparagraph (B).

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5 U.S.C. § 8907 (2005). Information to individuals eligible to enroll

(a) The Office of Personnel Management shall make available to each individual eligible to enroll in a health benefits plan under this chapter such information, in a form acceptable to the Office after consultation with the carrier, as may be necessary to enable the individual to exercise an informed choice among the types of plans described by sections 8903 and 8903a of this title.

(b) Each enrollee in a health benefits plan shall be issued an appropriate document setting forth or summarizing the –

(1) services or benefits, including maximums, limitations, and exclusions, to which the enrollee or the enrollee and any eligible family members are entitled thereunder;

(2) procedure for obtaining benefits; and

(3) principal provisions of the plan affecting the enrollee and any eligible family members.

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5 U.S.C. § 8912 (2005). Jurisdiction of courts

The district courts of the United States have original jurisdiction, concurrent with the United States Claims Court [United States Court of Federal Claims], of a civil action or claim against the United States founded on this chapter.

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5 C.F.R. § 890.105 Filing claims for payment or service.

(a) General. (1) Each health benefits carrier resolves claims filed under the plan. All health benefits claims must be submitted initially to the carrier of the covered individual's health benefits plan. If the carrier denies a claim (or a portion of a claim), the covered individual may ask the carrier to reconsider its denial. If the carrier affirms its denial or fails to respond as required by paragraph (c) of this section, the covered individual may ask OPM to review the claim. A covered individual must exhaust both the carrier and OPM review processes specified in this section before seeking judicial review of the denied claim.

(2) This section applies to covered individuals and to other individuals or entities who are acting on the behalf of a covered individual and who have the covered individual's specific written consent to pursue payment of the disputed claim.

(b) Time limits for reconsidering a claim. (1) The covered individual has 6 months from the date of the notice to the covered individual that a claim (or a portion of a claim) was denied by the carrier in which to submit a written request for reconsideration to the carrier. The time limit for requesting reconsideration may be extended when the covered individual shows that he or she was prevented by circumstances beyond his or her control from making the request within the time limit.

(2) The carrier has 30 days after the date of receipt of a timely-filed request for reconsideration to:

(i) Affirm the denial in writing to the covered individual;

(ii) Pay the bill or provide the service; or

(iii) Request from the covered individual or provider additional information needed to make a decision on the claim. The carrier must simultaneously notify the covered individual of the information requested if it requests additional information from a provider. The carrier has 30 days after the date the information is received to affirm the denial in writing to the covered individual or pay the bill or provide the service. The carrier must make its decision based on the evidence it has if the covered individual or provider does not respond within 60 days after the date of the carrier's notice requesting additional information. The carrier must then send written notice to the covered

individual of its decision on the claim. The covered individual may request OPM review as provided in paragraph (b)(3) of this section if the carrier fails to act within the time limit set forth in this paragraph (b)(2)(iii).

(3) The covered individual may write to OPM and request that OPM review the carrier's decision if the carrier either affirms its denial of a claim or fails to respond to a covered individual's written request for reconsideration within the time limit set forth in paragraph (b)(2) of this section. The covered individual must submit the request for OPM review within the time limit specified in paragraph (e)(1) of this section.

(4) The carrier may extend the time limit for a covered individual's submission of additional information to the carrier when the covered individual shows he or she was not notified of the time limit or was prevented by circumstances beyond his or her control from submitting the additional information.

(c) Information required to process requests for reconsideration. (1) The covered individual must put the request to the carrier to reconsider a claim in writing and give the reasons, in terms of applicable brochure provisions, that the denied claim should have been approved.

(2) If the carrier needs additional information from the covered individual to make a decision, it must:

(i) Specifically identify the information needed;

(ii) State the reason the information is required to make a decision on the claim;

(iii) Specify the time limit (60 days after the date of the carrier's request) for submitting the information; and

(iv) State the consequences of failure to respond within the time limit specified, as set out in paragraph (b)(2) of this section.

(d) Carrier determinations. The carrier must provide written notice to the covered individual of its determination. If the carrier affirms the initial denial, the notice must inform the covered individual of:

(1) The specific and detailed reasons for the denial;

(2) The covered individual's right to request a review by OPM; and

(3) The requirement that requests for OPM review must be received within 90 days after the date of the carrier's denial notice and include a copy of the denial notice as well as documents to support the covered individual's position.

(e) OPM review. (1) If the covered individual seeks further review of the denied claim, the covered individual must make a request to OPM to review the carrier's decision. Such a request to OPM must be made:

(i) Within 90 days after the date of the carrier's notice to the covered individual that the denial was affirmed;

(ii) If the carrier fails to respond to the covered individual as provided in paragraph (b)(2) of this section, within 120 days after the date of the covered individual's timely request for reconsideration by the carrier; or

(iii) Within 120 days after the date the carrier requests additional information from the covered individual, or the date the covered individual is notified that the

carrier is requesting additional information from a provider. OPM may extend the time limit for a covered individual's request for OPM review when the covered individual shows he or she was not notified of the time limit or was prevented by circumstances beyond his or her control from submitting the request for OPM review within the time limit.

(2) In reviewing a claim denied by the carrier, OPM may:

(i) Request that the covered individual submit additional information;

(ii) Obtain an advisory opinion from an independent physician;

(iii) Obtain any other information as may in its judgment be required to make a determination; or

(iv) Make its decision based solely on the information the covered individual provided with his or her request for review.

(3) When OPM requests information from the carrier, the carrier must release the information within 30 days after the date of OPM's written request unless a different time limit is specified by OPM in its request.

(4) Within 90 days after receipt of the request for review, OPM will either:

(i) Give a written notice of its decision to the covered individual and the carrier; or

(ii) Notify the individual of the status of the review. If OPM does not receive requested evidence within 15 days after expiration of the applicable time limit in paragraph

(e)(3) of this section, OPM may make its decision based solely on information available to it at that time and give a written notice of its decision to the covered individual and to the carrier.

(5) OPM, upon its own motion, may reopen its review if it receives evidence that was unavailable at the time of its original decision.

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5 C.F.R. § 890.107 Court Review.

(a) A suit to compel enrollment under § 890.102 must be brought against the employing office that made the enrollment decision.

(b) A suit to review the legality of OPM's regulations under this part must be brought against the Office of Personnel Management.

(c) Federal Employees Health Benefits (FEHB) carriers resolve FEHB claims under authority of Federal statute. A covered individual may seek judicial review of OPM's final action on the denial of a health benefits claim. A legal action to review final action by OPM involving such denial of health benefits must be brought against OPM and not against the carrier or carrier's subcontractors. The recovery in such a suit shall be limited to a court order directing OPM to require the carrier to pay the amount of benefits in dispute.

(d) An action under paragraph (c) of this section to recover on a claim for health benefits:

(1) May not be brought prior to exhaustion of the administrative remedies provided in § 890.105;

(2) May not be brought later than December 31 of the 3rd year after the year in which the care or service was provided; and

(3) Will be limited to the record that was before OPM when it rendered its decision affirming the carrier's denial of benefits.

APPENDIX G

United States
Office of
Personnel Management Washington, D.C. 20415

DECLARATION OF BEN CHUE, M.D.

Ben Chu, M.D., under penalty of perjury under the laws of the State of Washington and of the United States, hereby declares as follows:

1. I am a board-certified medical oncologist. A true and correct copy of my curriculum vitae is attached.

2. I am employed at the Seattle Cancer Treatment and Wellness Center. I have previously worked at the Fred Hutchinson Cancer Research Center, the University of Washington Cancer Center and Virginia Mason Hospital as a fellow in oncology, with extensive experience in medical oncology, hematology and bone marrow transplantations.

3. Douglas Nelson is currently my patient. Mr. Nelson was diagnosed with [unresectable] mesothelioma in 1997.

4. Mesothelioma is an incurable cancer in the lining of the lung caused by exposure to asbestos. Mesothelioma is a devastating disease because the patient basically slowly suffocates to death as the cancerous tumor spreads throughout the patient's lungs.

5. The life expectancy for patients with mesothelioma is generally ~~two or three~~ three to six months from the date of diagnosis. The longest most patients live from the date of diagnosis is two years.

6. Up until the year 2000, there were no accepted treatments for mesothelioma; i.e., there were no

available treatments for mesothelioma that would benefit the patient.

7. Only recently have there been developments in treating mesothelioma with chemotherapy. Chemotherapy increases the life expectancy in some patients with mesothelioma. Chemotherapy has only very recently became an accepted practice for treating mesothelioma.

8. Mr. Nelson started chemotherapy in February 2001, and has continued with this treatment since then. He appears to have benefited significantly from chemotherapy, and he is doing relatively well.

9. It is astounding that Mr. Nelson is still alive. He has out-lived all of the statistics for patients with mesothelioma.

10. No one in 1998 could have predicted that Mr. Nelson would still be alive today and that he would be undergoing the treatments that I have described.

I declare under penalty of perjury under the laws of the State of Washington and of the United States, that the foregoing is true and correct.

EXECUTED at Seattle, Washington, this 3 day of October, 2002.

/s/ Ben Chue
BEN CHUE, M.D.

APPENDIX H

U.S. Department of Labor
Employment Standards Administration
Office of Workers' Compensation Programs
1111 Third Ave., Suite 650
Seattle, WA 98101-3212
Telephone # (206) 398-8100
Fax: (206) 398-8151
(206) 398-8100
Medical Authorization
Fax (206) 398-8152

February 26, 2002

File Number: 14-0321721
Date of Injury: 12/02/1996
Employee:
DOUGLAS L. NELSON

SCHROETER GOLDMARK AND BENDER
ATTN: MS ANGELA MILLER/LEGAL ASST
500 CENTRAL BUILDING 810 THIRD AVE
SEATTLE WA 98104

Dear MS MILLER:

This letter corrects the previous letter I sent to you on the subject of updating the surplus amount on this claim. Please be advised that you had one statement of recovery which I did not have in the amount of $93,965.21 which, when added to the previous surplus of $426,365.56, makes a new surplus of $520,330.77. Thank you for your help in this matter.

Sincerely,

/s/ James D. Graves
JAMES D. GRAVES
Third Party Examiner
CA9999– –

APPENDIX I

U.S. Department of Labor

Employment Standards Administration
Office of Workers' Compensation Programs
1111 Third Avenue, Suite 650
Seattle, WA 98101-3211
Telephone # (206) 553-5508

February 03,1998

(206) 553-5508

File Number: 14-0321721
Date of Injury: 12/02/1996
Employee:
DOUGLAS L. NELSON

DOUGLAS L. NELSON
405 PINEWOOD DR NE
BREMERTON, WA. 98310

Dear Mr. NELSON:

Our records show that you obtained a recovery from the third party responsible for your injury. Item 3 below shows the amount remaining that must be offset by additional medical expenses or disability benefits before any further payments can be made on account of the injury. Medical treatment at the expense of this office cannot be authorized until the amount shown under item 3 is exceeded.

Any additional compensation due in your case will be credited against the remainder of the recovery upon submission of appropriate claim forms. Additional medical expenses will be credited upon presentation of itemized receipted bills for the accepted condition.

1. Third party recovery $112,500.00
2. Less:
   a. Personal property damage $00.00

b. Attorney's fee and costs $43,007.82

c. Net recovery $69,492.18

d. One-fifth net recovery $13,898.44

e. Medical expenses paid by you including payment to Federal medical facilities..... $00.00

f. Adjusted net recovery $55,593.74

g. Payments made by the OWCP $6,887.10

3. Remainder $48,706.64

For more detailed explanation, please see the attached EN1044.

Sincerely,

JAMES D. GRAVES
Third Party Examiner

DEPARTMENT OF THE NAVY
CTP: GLORIA DUMAS
PUGET SOUND NAVAL SHIPYARD
CODE 1113 1
1400 FARRAGUT AVE
BREMERTON WA 98314

TAA [SCHROETER GOLDMARK AND BENDER
500 CENTRAL BUILDING
810 THIRD AVE
SEATTLE WA 98104]

File Number: 14-0321721
Employee: DOUGLAS L. NELSON

The Federal Employees' Compensation Act, at 5 U.S.C. 8132, provides that money or property realized from a third party recovery shall be applied by the employee as follows, after deducting the costs of the recovery and a reasonable attorney's fee, as applicable:

You have the right to retain one-fifth of the net amount of the money or value of other property remaining after the costs of a recovery or settlement have been deducted. This is why we have designated one-fifth of the net recovery in item 2d on the attached CA1044 as yours and excluded it from our computation.

Where benefits have been paid pursuant to the Act, you must refund to the United States the amount of the benefits paid to you and on your behalf. However, if you were represented by an attorney, you have the right to retain an amount equivalent to a reasonable attorney's fee proportionate to the refund of OWCP disbursements. In item 2g we have allowed full credit for the amount paid by the OWCP on account of the injury. If you were represented by an attorney, you are required to refund only a portion of that amount. The difference, which you are allowed to keep, represents the Government's participation in the fee your attorney received from the proceeds of the gross recovery.

The amount shown in item 3 is the recovery which remains after the payment of the required refund. This remainder, which you keep, is the amount against which we will credit any future payments of compensation or medical expenses on account of the same injury.

If you have not previously received benefits for disability or for a permanent impairment involving total or partial loss or loss of use of a member, function, or organ of the body as specified in the Act and its regulations (including a serious disfigurement of the face, head, or neck), you should file a claim on Form CA-7 so benefits due can be

credited. Continuing claims for further periods of disability should be submitted on Form CA-8.

APPENDIX J

2002 KPS Health Plans

Introduction

KPS Health Plans
400 Warren Avenue, P.O. Box 339
Bremerton, Washington 98337

This brochure describes the benefits of KPS Health Plans under our contract (CS 1767) with the Office of Personnel Management (OPM), as authorized by the Federal Employees Health Benefits law. This brochure is the official statement of benefits. No oral statement can modify or otherwise affect the benefits, limitations, and exclusions of this brochure.

If you are enrolled in this Plan, you are entitled to the benefits described in this brochure. If you are enrolled for Self and Family coverage, each eligible family member is also entitled to these benefits. You do not have a right to benefits that were available before January 1, 2002, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2002, and are summarized on page 6. Rates are shown at the end of this brochure.

Plain Language

Teams of Government and health plans' staff worked on all FEHB brochures to make them responsive, accessible, and understandable to the public. For instance,

- Except for necessary technical terms, we use common words. For instance, "you" means the enrollee or family member; "we" means KPS Health Plans.
- We limit acronyms to ones you know. FEHB is the Federal Employees Health Benefits Program. OPM is the Office of Personnel Management. If we use others, we tell you what they mean first.
- Our brochure and other FEHB plans' brochures have the same format and similar descriptions to help you compare plans.

If you have comments or suggestions about how to improve the structure of this brochure, let OPM know. Visit OPM's "Rate Us" feedback area at www.opm.gov/insure or e-mail OPM at fehbwebcomments@opm.gov. You may also write to OPM at the Office of Personnel Management, Office of Insurance Planning and Evaluation Division, 1900 E. Street, NW Washington, DC 20416-3650.

Inspector General Advisory

Stop health care fraud! Fraud increases the cost of health care for everyone. If you suspect that a physician, pharmacy, or hospital has charged you for services you did not receive, billed you twice for the same service, or misrepresented any information, do the following:

- Call the provider and ask for an explanation. There may be an error.
- If the provider does not resolve the matter, call us at

360/1478-6796 and explain the situation.

- If we do not resolve the issue, call or write

THE HEALTH CARE FRAUD HOTLINE
202/418-3300

The United States Office of Personnel Management
Office of the Inspector General
Fraud Hotline
1900 E Street, NW, Room 6400
Washington, DC 20415

Penalties for Fraud

Anyone who falsifies a claim to obtain FEHB Program benefits can be prosecuted for fraud. Also, the Inspector General may investigate anyone who uses an ID card if the person tries to obtain services for someone who is not an eligible family member, or are no longer enrolled in the Plan and try to obtain benefits. Your agency may also take administrative action against you.

* * *

Workers' Compensation

We do not cover services that:

- You need because of a work-place-related illness or injury that the Office of Workers' Compensation Programs (OWCP) or a similar Federal or State agency determines they must provide; or

	• OWCP or a similar agency pays for through a third party injury settlement or other similar proceeding that is based on a claim you filed under OWCP or similar laws. Once OWCP or similar agency pays its maximum benefits for your treatment, we will cover your care. You must use our providers.
Medicaid	When you have this Plan and Medicaid, we pay first.
When other Government agencies are responsible for your care	We do not cover services and supplies when a local, State, or Federal Government agency directly or indirectly pays for them.
When others are responsible for injuries	When you receive money to compensate you for medical or hospital care for injuries or illness caused by another person, you must reimburse us for any expenses we paid. However, we will cover the cost of treatment that exceeds the amount you received in the settlement. If you do not seek damages you must agree to let us try. This is called subrogation. If you need more information, contact us for our subrogation procedures.